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## CHAMBER ACTION

1 The Commerce Council recommends the following:

2  
3 **Council/Committee Substitute**

4 Remove the entire bill and insert:

5 A bill to be entitled

6 An act relating to health insurance; amending s. 408.05,  
7 F.S.; changing the due date for a report from the Agency  
8 for Health Care Administration regarding the State Center  
9 for Health Statistics; changing the release dates for  
10 certain data collected by the State Center for Health  
11 Statistics; amending s. 408.909, F.S.; providing an  
12 additional criterion for the Office of Insurance  
13 Regulation to disapprove or withdraw approval of health  
14 flex plans; amending s. 627.413, F.S.; authorizing  
15 insurers and health maintenance organizations to offer  
16 policies or contracts providing for a high deductible plan  
17 meeting federal requirements and in conjunction with a  
18 health savings account; amending s. 627.6402, F.S.;  
19 revising provisions for healthy lifestyle rebates for an  
20 individual health insurance policy; providing exceptions;  
21 providing application; amending s. 627.6487, F.S.;  
22 revising the definition of the term "eligible individual"  
23 for purposes of obtaining coverage in the Florida Health

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Insurance Plan; amending s. 627.64872, F.S.; revising definitions; changing references to the Director of the Office of Insurance Regulation to the Commissioner of Insurance Regulation; deleting obsolete language; providing additional eligibility criteria; reducing premium rate limitations; revising requirements for sources of additional revenue; authorizing the board to cancel policies under inadequate funding conditions; providing a limitation; defining the term "health insurance" for purposes of certain assessments; providing an exclusion; specifying a maximum provider reimbursement rate; requiring licensed providers to accept assignment of plan benefits and consider certain payments as payments in full; authorizing the board to update a required actuarial study; providing study criteria; amending s. 627.65626, F.S.; revising criteria for healthy lifestyle rebates for group and similar health insurance policies provided by health insurers; providing exceptions; providing application; amending s. 627.6692, F.S.; extending a time period within which eligible employees may apply for continuation of coverage; amending s. 627.6699, F.S.; revising availability of coverage provision of the Employee Health Care Access Act; including high deductible plans meeting federal health savings account plan requirements; revising membership of the board of the small employer health reinsurance program; revising certain reporting dates relating to program losses and assessments; requiring the board to advise executive and

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legislative entities on health insurance issues; providing requirements; amending s. 641.27, F.S.; increasing the interval at which the office examines health maintenance organizations; deleting authorization for the office to accept an audit report from a certified public accountant in lieu of conducting its own examination; increasing an expense limitation; amending s. 641.31, F.S.; revising criteria for healthy lifestyle rebates for health maintenance organizations; providing exceptions; providing application; providing an appropriation; providing application; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (1) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 State Center for Health Statistics.--

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(1) Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the

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80 | initial plan to the Governor, the President of the Senate, and  
81 | the Speaker of the House of Representatives by January ~~March~~ 1,  
82 | 2006 ~~2005~~, and shall update the plan and report on the status of  
83 | its implementation annually thereafter. The agency shall also  
84 | make the plan and status report available to the public on its  
85 | Internet website. As part of the plan, the agency shall identify  
86 | the process and timeframes for implementation, any barriers to  
87 | implementation, and recommendations of changes in the law that  
88 | may be enacted by the Legislature to eliminate the barriers. As  
89 | preliminary elements of the plan, the agency shall:

90 |       1. Make available performance outcome and patient charge  
91 | data collected from health care facilities pursuant to s.  
92 | 408.061(1)(a) and (2). The agency shall determine which  
93 | conditions and procedures, performance outcomes, and patient  
94 | charge data to disclose based upon input from the council. When  
95 | determining which conditions and procedures are to be disclosed,  
96 | the council and the agency shall consider variation in costs,  
97 | variation in outcomes, and magnitude of variations and other  
98 | relevant information. When determining which performance  
99 | outcomes to disclose, the agency:

100 |       a. Shall consider such factors as volume of cases; average  
101 | patient charges; average length of stay; complication rates;  
102 | mortality rates; and infection rates, among others, which shall  
103 | be adjusted for case mix and severity, if applicable.

104 |       b. May consider such additional measures that are adopted  
105 | by the Centers for Medicare and Medicaid Studies, National  
106 | Quality Forum, the Joint Commission on Accreditation of  
107 | Healthcare Organizations, the Agency for Healthcare Research and

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108    Quality, or a similar national entity that establishes standards  
109    to measure the performance of health care providers, or by other  
110    states.

111  
112    When determining which patient charge data to disclose, the  
113    agency shall consider such measures as average charge, average  
114    net revenue per adjusted patient day, average cost per adjusted  
115    patient day, and average cost per admission, among others.

116        2.    Make available performance measures, benefit design,  
117    and premium cost data from health plans licensed pursuant to  
118    chapter 627 or chapter 641. The agency shall determine which  
119    performance outcome and member and subscriber cost data to  
120    disclose, based upon input from the council. When determining  
121    which data to disclose, the agency shall consider information  
122    that may be required by either individual or group purchasers to  
123    assess the value of the product, which may include membership  
124    satisfaction, quality of care, current enrollment or membership,  
125    coverage areas, accreditation status, premium costs, plan costs,  
126    premium increases, range of benefits, copayments and  
127    deductibles, accuracy and speed of claims payment, credentials  
128    of physicians, number of providers, names of network providers,  
129    and hospitals in the network. Health plans shall make available  
130    to the agency any such data or information that is not currently  
131    reported to the agency or the office.

132        3.    Determine the method and format for public disclosure  
133    of data reported pursuant to this paragraph. The agency shall  
134    make its determination based upon input from the Comprehensive  
135    Health Information System Advisory Council. At a minimum, the

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136 data shall be made available on the agency's Internet website in  
137 a manner that allows consumers to conduct an interactive search  
138 that allows them to view and compare the information for  
139 specific providers. The website must include such additional  
140 information as is determined necessary to ensure that the  
141 website enhances informed decisionmaking among consumers and  
142 health care purchasers, which shall include, at a minimum,  
143 appropriate guidance on how to use the data and an explanation  
144 of why the data may vary from provider to provider. The data  
145 specified in subparagraph 1. shall be released no later than  
146 January 1, 2006, for the reporting of infection rates, and no  
147 later than October ~~March~~ 1, 2005, for mortality rates and  
148 complication rates. The data specified in subparagraph 2. shall  
149 be released no later than October ~~March~~ 1, 2006.

150       Section 2. Paragraph (b) of subsection (3) of section  
151 408.909, Florida Statutes, is amended to read:

152       408.909 Health flex plans.--

153       (3) PROGRAM.--The agency and the office shall each approve  
154 or disapprove health flex plans that provide health care  
155 coverage for eligible participants. A health flex plan may limit  
156 or exclude benefits otherwise required by law for insurers  
157 offering coverage in this state, may cap the total amount of  
158 claims paid per year per enrollee, may limit the number of  
159 enrollees, or may take any combination of those actions. A  
160 health flex plan offering may include the option of a  
161 catastrophic plan supplementing the health flex plan.

162       (b) The office shall develop guidelines for the review of  
163 health flex plan applications and provide regulatory oversight

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of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; ~~or~~

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required pursuant to s. 624.404(3).

Section 3. Subsection (6) is added to section 627.413, Florida Statutes, to read:

627.413 Contents of policies, in general;  
identification.--

(6) Notwithstanding any other provision of the Florida Insurance Code that is in conflict with federal requirements for a health savings account qualified high deductible health plan, an insurer, or a health maintenance organization subject to part I of chapter 641, which is authorized to issue health insurance in this state may offer for sale an individual or group policy

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192 or contract that provides for a high deductible plan that meets  
193 the federal requirements of a health savings account plan and  
194 which is offered in conjunction with a health savings account.

195 Section 4. Section 627.6402, Florida Statutes, is amended  
196 to read:

197 627.6402 Insurance rebates for healthy lifestyles.--

198 (1) Any rate, rating schedule, or rating manual for an  
199 individual health insurance policy filed with the office may  
200 ~~shall~~ provide for an appropriate rebate of premiums paid in the  
201 last ~~calendar~~ year when the individual covered by such plan is  
202 enrolled in and maintains participation in any health wellness,  
203 maintenance, or improvement program approved by the health plan.  
204 The rebate may be based on premiums paid in the last calendar  
205 year or the last policy year. The individual must provide  
206 evidence of demonstrative maintenance or improvement of the  
207 individual's health status as determined by assessments of  
208 agreed-upon health status indicators between the individual and  
209 the health insurer, including, but not limited to, reduction in  
210 weight, body mass index, and smoking cessation. Any rebate  
211 provided by the health insurer is presumed to be appropriate  
212 unless credible data demonstrates otherwise, or unless such  
213 rebate program requires the insured to incur costs to qualify  
214 for the rebate which equal or exceed the value of the rebate,  
215 but in no event shall the rebate ~~not~~ exceed 10 percent of paid  
216 premiums.

217 (2) The premium rebate authorized by this section shall be  
218 effective for an insured on an annual basis, unless the  
219 individual fails to maintain or improve his or her health status

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while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program.

(3) The program shall be available for all policies issued on or after July 1, 2005.

Section 5. Paragraph (b) of subsection (3) of section 627.6487, Florida Statutes, is amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollments. However, a person whose previous coverage was under the Florida Health

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Insurance Plan as specified in s. 627.64872 is not an eligible individual as defined in s. 627.6487(3)(a);

Section 6. Paragraphs (b), (c), and (n) of subsection (2) and subsections (3), (6), (9), and (15) of section 627.64872, Florida Statutes, are amended, subsection (20) of said section is renumbered as subsection (21), and a new subsection (20) is added to said section, to read:

627.64872 Florida Health Insurance Plan.--

(2) DEFINITIONS.--As used in this section:

(b) "Commissioner" means the Commissioner of Insurance Regulation.

(c) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

~~(c) "Director" means the Director of the Office of Insurance Regulation.~~

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months and who physically resides in this state not less than 185 days per year.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner ~~director~~ or his or her designated representative, who shall serve as a member of the board and shall be its chair, and an additional eight members, five of whom shall be appointed

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275 by the Governor, at least two of whom shall be individuals not  
276 representative of insurers or health care providers, one of whom  
277 shall be appointed by the President of the Senate, one of whom  
278 shall be appointed by the Speaker of the House of  
279 Representatives, and one of whom shall be appointed by the Chief  
280 Financial Officer.

281 (b) The term to be served on the board by the commissioner  
282 ~~Director of the Office of Insurance Regulation~~ shall be  
283 determined by continued employment in such position. The  
284 remaining initial board members shall serve for a period of time  
285 as follows: two members appointed by the Governor and the  
286 members appointed by the President of the Senate and the Speaker  
287 of the House of Representatives shall serve a term of 2 years;  
288 and three members appointed by the Governor and the Chief  
289 Financial Officer shall serve a term of 4 years. Subsequent  
290 board members shall serve for a term of 3 years. A board  
291 member's term shall continue until his or her successor is  
292 appointed.

293 (c) Vacancies on the board shall be filled by the  
294 appointing authority, such authority being the Governor, the  
295 President of the Senate, the Speaker of the House of  
296 Representatives, or the Chief Financial Officer. The appointing  
297 authority may remove board members for cause.

298 (d) The commissioner ~~director~~, or his or her recognized  
299 representative, shall be responsible for any organizational  
300 requirements necessary for the initial meeting of the board  
301 which shall take place no later than September 1, 2004.

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(e) Members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties in accordance with s. 112.061.

(f) The board shall submit to the Financial Services Commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Financial Services Commission consistent with the date on which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after implementation ~~the appointment of the board of directors~~, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Financial Services Commission shall adopt such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Financial Services Commission.

(6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--

~~(a) By no later than December 1, 2004, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an~~

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~~actuarial study conducted by the board to determine, including,  
but not limited to:~~

~~1. The impact the creation of the plan will have on the  
small group insurance market and the individual market on  
premiums paid by insureds. This shall include an estimate of the  
total anticipated aggregate savings for all small employers in  
the state.~~

~~2. The number of individuals the pool could reasonably  
cover at various funding levels, specifically, the number of  
people the pool may cover at each of those funding levels.~~

~~3. A recommendation as to the best source of funding for  
the anticipated deficits of the pool.~~

~~4. The effect on the individual and small group market by  
including in the Florida Health Insurance Plan persons eligible  
for coverage under s. 627.6487, as well as the cost of including  
these individuals.~~

~~The board shall take no action to implement the Florida Health  
Insurance Plan, other than the completion of the actuarial study  
authorized in this paragraph, until funds are appropriated for  
startup cost and any projected deficits.~~

~~(b)~~ No later than December 1, 2005, and annually  
thereafter, the board shall submit to the Governor, the  
President of the Senate, the Speaker of the House of  
Representatives, and the substantive legislative committees of  
the Legislature a report which includes an independent actuarial  
study to determine, including, but not be limited to:

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356        (a)1- The impact the creation of the plan has on the small  
357 group and individual insurance market, specifically on the  
358 premiums paid by insureds. This shall include an estimate of the  
359 total anticipated aggregate savings for all small employers in  
360 the state.

361        (b)2- The actual number of individuals covered at the  
362 current funding and benefit level, the projected number of  
363 individuals that may seek coverage in the forthcoming fiscal  
364 year, and the projected funding needed to cover anticipated  
365 increase or decrease in plan participation.

366        ~~3- A recommendation as to the best source of funding for~~  
367 ~~the anticipated deficits of the pool.~~

368        (c)4- A summarization of the activities of the plan in the  
369 preceding calendar year, including the net written and earned  
370 premiums, plan enrollment, the expense of administration, and  
371 the paid and incurred losses.

372        (d)5- A review of the operation of the plan as to whether  
373 the plan has met the intent of this section.

374        (9) ELIGIBILITY.--

375        (a) Any individual person who is and continues to be a  
376 resident of this state shall be eligible for coverage under the  
377 plan if:

378        1. Evidence is provided that the person received notices  
379 of rejection or refusal to issue substantially similar coverage  
380 for health reasons from at least two health insurers or health  
381 maintenance organizations. A rejection or refusal by an insurer  
382 offering only stop-loss, excess of loss, or reinsurance coverage

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with respect to the applicant shall not be sufficient evidence under this paragraph.

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

3. Is an eligible individual as defined in s. 627.6487(3), excluding s. 627.6487(3)(b)5.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) A person shall not be eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain such coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy or may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;~~-~~

2. The person is determined to be eligible for health care benefits under Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits;

3. The person voluntarily terminated plan coverage unless 12 months have elapsed since such termination;

4. The person is an inmate or resident of a public institution; or

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411           5. The person's premiums are paid for or reimbursed under  
412 any government-sponsored program or by any government agency or  
413 health care provider or by any health care provider sponsored or  
414 affiliated organization.

415           (d) Coverage shall cease:

416           1. On the date a person is no longer a resident of this  
417 state;

418           2. On the date a person requests coverage to end;

419           3. Upon the death of the covered person;

420           4. On the date state law requires cancellation or  
421 nonrenewal of the policy; ~~or~~

422           5. At the option of the plan, 30 days after the plan makes  
423 any inquiry concerning the person's eligibility or place of  
424 residence to which the person does not reply; or ~~or~~

425           6. Upon failure of the insured to pay for continued  
426 coverage.

427           (e) Except under the circumstances described in this  
428 subsection, coverage of a person who ceases to meet the  
429 eligibility requirements of this subsection shall be terminated  
430 at the end of the policy period for which the necessary premiums  
431 have been paid.

432           (15) FUNDING OF THE PLAN.--

433           (a) Premiums.--

434           1. The plan shall establish premium rates for plan  
435 coverage as provided in this section. Separate schedules of  
436 premium rates based on age, sex, and geographical location may  
437 apply for individual risks. Premium rates and schedules shall be  
438 submitted to the office for approval prior to use.

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2. Initial rates for plan coverage shall be limited to no more than 200 percent ~~300 percent~~ of rates established for individual standard risks as specified in s. 627.6675(3)(c). Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, but in no event shall premiums exceed the 200-percent ~~300-percent~~ rate limitation provided in this section. Notwithstanding the 200-percent ~~300-percent~~ rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees, except those made eligible for coverage by subparagraph (9)(a)3.

3. For the purposes of determining assessments under this section, the term "health insurance" means any hospital and medical expense incurred policy, minimum premium plan, stop-loss coverage, health maintenance organization contract, prepaid health clinic contract, multiple-employer welfare arrangement contract, or fraternal benefit society health benefits contract, whether sold as an individual or group policy or contract. The term does not include a policy covering medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, or workers' compensation.

(b) Sources of additional revenue.--Any deficit incurred by the plan shall be ~~primarily~~ funded through amounts appropriated by the Legislature from general revenue sources,

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including, but not limited to, a portion of the ~~annual growth in~~  
existing net insurance premium taxes in an amount not less than  
the anticipated losses and reserve requirements for existing  
policyholders. The board shall operate the plan in such a manner  
that the estimated cost of providing health insurance during any  
fiscal year will not exceed total income the plan expects to  
receive from policy premiums and funds appropriated by the  
Legislature, including any interest on investments. After  
determining the amount of funds appropriated to the board for a  
fiscal year, the board shall estimate the number of new policies  
it believes the plan has the financial capacity to insure during  
that year so that costs do not exceed income. The board shall  
take steps necessary to ensure that plan enrollment does not  
exceed the number of residents it has estimated it has the  
financial capacity to insure.

(c) In the event of inadequate funding, the board may  
cancel existing policies on a nondiscriminatory basis as  
necessary to remedy the situation. No policy may be canceled if  
a covered individual is currently making a claim.

(20) PROVIDER REIMBURSEMENT.--Notwithstanding any other  
provision of law, the maximum reimbursement rate to health care  
providers for all covered, medically necessary services shall be  
100 percent of Medicare's allowed payment amount for that  
particular provider and service. All licensed providers in this  
state shall accept assignment of plan benefits and consider the  
Medicare allowed payment amount as payment in full. By no later  
than December 1, 2005, the board shall update the actuarial  
study required by s. 627.64872(6), to include the impact of

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495 alternative methods of actuarially sound risk adjusted provider  
496 reimbursement methodologies, including capitated prepaid  
497 arrangements, that take into account such factors as age, sex,  
498 geographic variations, case mix, and access to specialty medical  
499 care. The board shall submit the updated actuarial study to the  
500 Governor, the President of the Senate, and the Speaker of the  
501 House no later than December 1, 2005.

502 Section 7. Section 627.65626, Florida Statutes, is amended  
503 to read:

504 627.65626 Insurance rebates for healthy lifestyles.--

505 (1) Any rate, rating schedule, or rating manual for a  
506 health insurance policy, which provides creditable coverage as  
507 defined in s. 627.6561(5), filed with the office shall provide  
508 for an appropriate rebate of premiums paid in the last policy  
509 year, contract year, or calendar year when the majority of  
510 members of a health plan have enrolled and maintained  
511 participation in any health wellness, maintenance, or  
512 improvement program offered by the group policyholder and the  
513 health plan employer. The rebate may be based upon premiums paid  
514 in the last calendar year or policy year. The group employer  
515 must provide evidence of demonstrative maintenance or  
516 improvement of the enrollees' health status as determined by  
517 assessments of agreed-upon health status indicators between the  
518 policyholder employer and the health insurer, including, but not  
519 limited to, reduction in weight, body mass index, and smoking  
520 cessation. Any rebate provided by the health insurer is presumed  
521 to be appropriate unless credible data demonstrates otherwise or  
522 unless such rebate program requires the insured to incur costs

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523 to qualify for the rebate which equal or exceed the value of the  
524 rebate, but in no event shall the rebate ~~not~~ exceed 10 percent  
525 of paid premiums.

526 (2) The premium rebate authorized by this section shall be  
527 effective for an insured on an annual basis unless the number of  
528 participating employees or members on the policy renewal  
529 anniversary becomes less than the majority of the employees or  
530 members eligible for participation in the wellness program.

531 (3) The program shall be available for all policies issued  
532 on or after July 1, 2005.

533 Section 8. Paragraphs (d) and (j) of subsection (5) of  
534 section 627.6692, Florida Statutes, are amended to read:

535 627.6692 Florida Health Insurance Coverage Continuation  
536 Act.--

537 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--

538 (d)1. A qualified beneficiary must give written notice to  
539 the insurance carrier within 63 ~~30~~ days after the occurrence of  
540 a qualifying event. Unless otherwise specified in the notice, a  
541 notice by any qualified beneficiary constitutes notice on behalf  
542 of all qualified beneficiaries. The written notice must inform  
543 the insurance carrier of the occurrence and type of the  
544 qualifying event giving rise to the potential election by a  
545 qualified beneficiary of continuation of coverage under the  
546 group health plan issued by that insurance carrier, except that  
547 in cases where the covered employee has been involuntarily  
548 discharged, the nature of such discharge need not be disclosed.  
549 The written notice must, at a minimum, identify the employer,  
550 the group health plan number, the name and address of all

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551 | qualified beneficiaries, and such other information required by  
552 | the insurance carrier under the terms of the group health plan  
553 | or the commission by rule, to the extent that such information  
554 | is known by the qualified beneficiary.

555 |       2. Within 14 days after the receipt of written notice  
556 | under subparagraph 1., the insurance carrier shall send each  
557 | qualified beneficiary by certified mail an election and premium  
558 | notice form, approved by the office, which form must provide for  
559 | the qualified beneficiary's election or nonelection of  
560 | continuation of coverage under the group health plan and the  
561 | applicable premium amount due after the election to continue  
562 | coverage. This subparagraph does not require separate mailing of  
563 | notices to qualified beneficiaries residing in the same  
564 | household, but requires a separate mailing for each separate  
565 | household.

566 |       (j) Notwithstanding paragraph (b), if a qualified  
567 | beneficiary in the military reserve or National Guard has  
568 | elected to continue coverage and is thereafter called to active  
569 | duty and the coverage under the group plan is terminated by the  
570 | beneficiary or the carrier due to the qualified beneficiary  
571 | becoming eligible for TRICARE (the health care program provided  
572 | by the United States Defense Department), the 18-month period or  
573 | such other applicable maximum time period for which the  
574 | qualified beneficiary would otherwise be entitled to continue  
575 | coverage is tolled during the time that he or she is covered  
576 | under the TRICARE program. Within 63 ~~30~~ days after the federal  
577 | TRICARE coverage terminates, the qualified beneficiary may elect  
578 | to continue coverage under the group health plan, retroactively

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579 to the date coverage terminated under TRICARE, for the remainder  
580 of the 18-month period or such other applicable time period,  
581 subject to termination of coverage at the earliest of the  
582 conditions specified in paragraph (b).

583 Section 9. Paragraph (c) of subsection (5) and paragraphs  
584 (b) and (j) of subsection (11) of section 627.6699, Florida  
585 Statutes, are amended, and paragraph (o) is added to subsection  
586 (11) of said section, to read:

587 627.6699 Employee Health Care Access Act.--

588 (5) AVAILABILITY OF COVERAGE.--

589 (c) Every small employer carrier must, as a condition of  
590 transacting business in this state:

591 1. Offer and issue all small employer health benefit plans  
592 on a guaranteed-issue basis to every eligible small employer,  
593 with 2 to 50 eligible employees, that elects to be covered under  
594 such plan, agrees to make the required premium payments, and  
595 satisfies the other provisions of the plan. A rider for  
596 additional or increased benefits may be medically underwritten  
597 and may only be added to the standard health benefit plan. The  
598 increased rate charged for the additional or increased benefit  
599 must be rated in accordance with this section.

600 2. In the absence of enrollment availability in the  
601 Florida Health Insurance Plan, offer and issue basic and  
602 standard small employer health benefit plans and a high  
603 deductible plan that meets the requirements of a health savings  
604 account plan or health reimbursement account as defined by  
605 federal law, on a guaranteed-issue basis, during a 31-day open  
606 enrollment period of August 1 through August 31 of each year, to

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every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.

3. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

(b)1. The program shall operate subject to the supervision and control of the board.

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2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:

a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration. ~~The director of the office shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the commission. Three members shall be selected from a list of health insurance carriers that issue individual health insurance policies. At least two of the three members selected must be reinsuring~~

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~~carriers. Two members shall be selected from a list of insurance agents who are actively engaged in the sale of health insurance.~~

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

3. The director of the office may remove a member for cause.

4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

~~5. The director of the office may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.~~

(j)1. Before July ~~March~~ 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The

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first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to

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718 be paid in the operation of the plan for the calendar year prior  
719 to the association's anticipated receipt of annual assessments  
720 for that calendar year. Any interim assessment is due and  
721 payable within 30 days after receipt by a carrier of the interim  
722 assessment notice. Interim assessment payments shall be credited  
723 against the carrier's annual assessment. Health benefit plan  
724 premiums and benefits paid by a carrier that are less than an  
725 amount determined by the board to justify the cost of collection  
726 may not be considered for purposes of determining assessments.

727 c. Subject to the approval of the office, the board shall  
728 make an adjustment to the assessment formula for reinsuring  
729 carriers that are approved as federally qualified health  
730 maintenance organizations by the Secretary of Health and Human  
731 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,  
732 if any, that restrictions are placed on them that are not  
733 imposed on other small employer carriers.

734 3. Before July ~~March~~ 1 of each year, the board shall  
735 determine and file with the office an estimate of the  
736 assessments needed to fund the losses incurred by the program in  
737 the previous calendar year.

738 4. If the board determines that the assessments needed to  
739 fund the losses incurred by the program in the previous calendar  
740 year will exceed the amount specified in subparagraph 2., the  
741 board shall evaluate the operation of the program and report its  
742 findings, including any recommendations for changes to the plan  
743 of operation, to the office within 180 ~~90~~ days following the end  
744 of the calendar year in which the losses were incurred. The  
745 evaluation shall include an estimate of future assessments, the

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746 administrative costs of the program, the appropriateness of the  
747 premiums charged and the level of carrier retention under the  
748 program, and the costs of coverage for small employers. If the  
749 board fails to file a report with the office within 180 ~~90~~ days  
750 following the end of the applicable calendar year, the office  
751 may evaluate the operations of the program and implement such  
752 amendments to the plan of operation the office deems necessary  
753 to reduce future losses and assessments.

754 5. If assessments exceed the amount of the actual losses  
755 and administrative expenses of the program, the excess shall be  
756 held as interest and used by the board to offset future losses  
757 or to reduce program premiums. As used in this paragraph, the  
758 term "future losses" includes reserves for incurred but not  
759 reported claims.

760 6. Each carrier's proportion of the assessment shall be  
761 determined annually by the board, based on annual statements and  
762 other reports considered necessary by the board and filed by the  
763 carriers with the board.

764 7. Provision shall be made in the plan of operation for  
765 the imposition of an interest penalty for late payment of an  
766 assessment.

767 8. A carrier may seek, from the office, a deferment, in  
768 whole or in part, from any assessment made by the board. The  
769 office may defer, in whole or in part, the assessment of a  
770 carrier if, in the opinion of the office, the payment of the  
771 assessment would place the carrier in a financially impaired  
772 condition. If an assessment against a carrier is deferred, in  
773 whole or in part, the amount by which the assessment is deferred

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774 may be assessed against the other carriers in a manner  
775 consistent with the basis for assessment set forth in this  
776 section. The carrier receiving such deferment remains liable to  
777 the program for the amount deferred and is prohibited from  
778 reinsuring any individuals or groups in the program if it fails  
779 to pay assessments.

780 (o) The board shall advise the office, the agency, the  
781 department, and other executive and legislative entities on  
782 health insurance issues. Specifically, the board shall:

783 1. Provide a forum for stakeholders, consisting of  
784 insurers, employers, agents, consumers, and regulators, in the  
785 private health insurance market in this state.

786 2. Review and recommend strategies to improve the  
787 functioning of the health insurance markets in this state with a  
788 specific focus on market stability, access, and pricing.

789 3. Make recommendations to the office for legislation  
790 addressing health insurance market issues and provide comments  
791 on health insurance legislation proposed by the office.

792 4. Meet at least three times each year. One meeting shall  
793 be held to hear reports and to secure public comment on the  
794 health insurance market, to develop any legislation needed to  
795 address health insurance market issues, and to provide comments  
796 on health insurance legislation proposed by the office.

797 5. By September 1 each year, issue a report to the office  
798 on the state of the health insurance market. The report shall  
799 include recommendations for changes in the health insurance  
800 market, results from implementation of previous recommendations  
801 and information on health insurance markets.

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Section 10. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 3 years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part.~~ However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations exceed a maximum of \$50,000 ~~\$20,000~~ for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation,

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liquidation, reorganization, conservation, or dissolution of  
life insurance companies.

Section 11. Subsection (40) of section 641.31, Florida  
Statutes, is amended to read:

641.31 Health maintenance contracts.--

(40)(a) Any group rate, rating schedule, or rating manual  
for a health maintenance organization policy, which provides  
creditable coverage as defined in s. 627.6561(5), filed with the  
office shall provide for an appropriate rebate of premiums paid  
in the last contract ~~calendar~~ year when the majority of the  
members of a health individual covered by such plan are is  
enrolled in and maintain ~~maintains~~ participation in any health  
wellness, maintenance, or improvement program offered by the  
group contract holder ~~approved by the health plan~~. The group  
~~individual~~ must provide evidence of demonstrative maintenance or  
improvement of ~~his or her~~ health status as determined by  
assessments of agreed-upon health status indicators between the  
group individual and the health insurer, including, but not  
limited to, reduction in weight, body mass index, and smoking  
cessation. Any rebate provided by the health maintenance  
organization insurer is presumed to be appropriate unless  
credible data demonstrates otherwise or unless such rebate  
program requires the insured to incur costs to qualify for the  
rebate which equal or exceed the value of the rebate, but in no  
event shall the rebate ~~not~~ exceed 10 percent of paid premiums.

(b) The premium rebate authorized by this section shall be  
effective for a subscriber ~~an insured~~ on an annual basis, unless  
the number of participating members on the contract renewal

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anniversary becomes less than the majority of the members  
eligible for participation in the wellness program individual  
fails to maintain or improve his or her health status while  
participating in an approved wellness program, or credible  
evidence demonstrates that the individual is not participating  
in the approved wellness program.

(c) The program shall be available for all contracts  
issued on or after July 1, 2005.

Section 12. The sum of \$5 million is appropriated from the  
General Revenue Fund to the Florida Health Insurance Plan for  
the purposes of implementing the plan.

Section 13. This act shall take effect July 1, 2005, and  
shall apply to all policies or contracts issued or renewed on or  
after July 1, 2005.